| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155224 | A. BUILDING 00<br>B. WING | 10/04/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLUMBIA HEALTHCARE CENTER | 621 W COLUMBIA ST<br>EVANSVILLE, IN 47710 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0000 | This visit was for the Investigation of Complaint IN00117509.<br><br>Complaint IN00117509 Substantiated, Federal/State deficiencies related to the allegations are cited at F309 and F514.<br><br>Survey dates:<br>October 3 and 4, 2012<br><br>Facility number: 000129<br>Provider number: 155224<br>AIM number: 100266780<br><br>Survey team:<br>Anne Marie Crays RN<br><br>Census bed type:<br>SNF/NF: 158<br>Total: 158<br><br>Census payor type:<br>Medicare: 27<br>Medicaid: 115<br>Other: 16<br>Total: 158<br><br>Sample: 4<br><br>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. | F0000 | The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.<br><br>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on or after October 24, 2012. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155224 | A. BUILDING 00<br>B. WING | 10/04/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLUMBIA HEALTHCARE CENTER | 621 W COLUMBIA ST<br>EVANSVILLE, IN 47710 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Quality review completed 10/5/12<br>Cathy Emswiller RN | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155224 | A. BUILDING 00<br>B. WING | 10/04/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLUMBIA HEALTHCARE CENTER | 621 W COLUMBIA ST<br>EVANSVILLE, IN 47710 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0309 SS=D | 483.25<br>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br>Based on interview and record review, the facility failed to ensure a nurse assessed a resident in distress when asked to do so by a CNA, for 1 of 3 residents reviewed for quality of care, in a sample of 3. Resident A<br><br>Findings include:<br><br>The closed clinical record of Resident A was reviewed on 10/3/12 at 4:50 P.M. The record indicated the resident was a "Full Code."<br><br>Progress Notes included the following notations:<br><br>9/30/12 at 10:10 P.M.: "Called to res. [resident] room per CNA. Res. awake et [and] alert et answering questions appropriately. Res. making some gurgling sounds in bronchial area. Auscultated lungs; rhonchi auscultated...Left room to get oxygen et call MD. CNA came out of res. room et stated res. had stopped breathing. CPR started et 911 called. | F0309 | F309 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>·Resident no longer in facility.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>·All residents have the potential to be affected by the alleged deficient practice.<br>·Nurse Managers will round daily to ensure any changes in condition are assessed and documented appropriately.<br>·Audit has been completed to ensure any resident with suspected change in condition has been assessed and findings reported to physician and family. Care plan and C.N.A. assignment | 10/24/2012 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155224 | A. BUILDING 00<br>B. WING | 10/04/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLUMBIA HEALTHCARE CENTER | 621 W COLUMBIA ST<br>EVANSVILLE, IN 47710 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | On 10/3/12 at 4:15 P.M., during interview with CNA # 1, she indicated she was working on the evening of 9/30/12. CNA # 1 indicated Resident A "didn't seem like his normal self." She indicated, "CNA # 2 was [Resident A's] aide." CNA # 1 indicated CNA # 2 asked RN # 1 and another nurse, whose name she was unsure of, to come down and look at Resident A, because he was having trouble breathing. CNA # 1 indicated RN # 1 told CNA # 2 that she "was going home." CNA # 1 indicated LPN # 2 then assessed the resident.<br><br>On 10/3/12 at 4:25 P.M., during interview with LPN # 2, she indicated she had taken a short break on the evening of 9/30/12, and when she came back to the unit, CNA # 2 informed her that Resident A " wasn't acting right." LPN # 2 indicated she assessed the resident at that time, and he was "real gurgly." LPN # 2 indicated she then left the room to call the physician and obtain oxygen.<br><br>On 10/3/12 at 4:45 P.M., during interview with RN # 1, she indicated she was working the evening of 9/30/12. RN # 1 indicated she hadn't been feeling well, and was supposed to go home early, when a CNA informed her "so and so is sick and I need you to check him." RN # 1 indicated | | sheets updated to reflect any changes.<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>·Licensed nursing staff has been educated on assessment and documentation policy. DNS/SDC trained all licensed nursing staff by October 24,2012.<br>·Licensed Nursing staff will be instructed to assess any resident identified by any staff member to be in distress.<br>·DNS/Designee/UM will conduct rounds daily on all shifts to validate that regular scheduled assessments are completed and assessments are done for any suspected change in condition.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>·Staff has been educated on assessment and documentation policy.<br>·The DNS/designee will complete CQI tool 5X weekly X 4 weeks, weekly X 4, and quarterly thereafter. For a minimum of 6 month<br>·All audit tools will be brought before the CQI committee monthly<br>·Any non-compliant issues may be addressed with re-education and/or disciplinary action up to and including termination. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155224 | A. BUILDING 00<br>B. WING | 10/04/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLUMBIA HEALTHCARE CENTER | 621 W COLUMBIA ST<br>EVANSVILLE, IN 47710 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | she informed the CNA to "please ask [LPN # 1], she's at the desk" because she was trying to finish up her work. RN # 1 indicated she was unaware if the CNA then asked anyone else. RN # 1 indicated she was counting the narcotics with RN # 2 later when a CNA came up and said the resident had stopped breathing, and then RN # 1 and RN # 2 ran to the room.<br><br>On 10/3/12 at 5:25 P.M., during interview with CNA # 2, she indicated that on 9/30/12, she had noticed Resident A "wasn't himself, " and was "panting, eyes were dancing, he wouldn't eat supper." CNA # 2 indicated at approximately 9:30 P.M. or 9:45 P.M., her nurse, LPN # 2, was taking a break, and she was very worried about Resident A. CNA # 2 indicated she went up to the nurses desk, and asked RN # 1 if she would "please come here and help me - I'm worried about [Resident A's] breathing." CNA # 2 indicated RN # 1 told her, "I'm getting ready to get off - go ask someone else." CNA # 2 indicated she was so surprised by RN # 1's comment that she just walked back to Resident A's room. CNA # 2 indicated at about that time LPN # 2 was coming back from break, so she asked her to come assess the resident. LPN # 2 immediately went into the resident's room, and assessed him. | | **Compliance date:** October 24, 2012 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155224 | A. BUILDING 00<br>B. WING | 10/04/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLUMBIA HEALTHCARE CENTER | 621 W COLUMBIA ST<br>EVANSVILLE, IN 47710 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | On 10/3/12 at 5:40 P.M., during interview with CNA # 3, she indicated she was working on the evening of 9/30/12. CNA # 3 indicated, "CNA # 2 came to me and wanted me to look at [Resident A]." CNA # 3 indicated Resident A's "skin was a funny color," and he was not breathing right. CNA # 3 indicated CNA # 2 said "a nurse told me to find someone else" to check on the resident.<br><br>On 10/4/12 at 9:10 A.M., during interview with CNA # 5, she indicated she was working the evening of 9/30/12. CNA # 5 indicated Resident A's nurse was "at lunch," and there were 2 nurses sitting at the desk. CNA # 5 indicated CNA # 2 asked them to check on Resident A, "but they didn't want to check on him."<br><br>On 10/4/12 at 10:00 A.M., during interview with the Administrator, she indicated she did receive reports regarding RN # 1 not assessing Resident A when asked, and RN # 1 had received a written warning regarding this.<br><br>This federal tag relates to Complaint IN00117509.<br><br>3.1-37(a) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155224 | A. BUILDING 00<br>B. WING | 10/04/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLUMBIA HEALTHCARE CENTER | 621 W COLUMBIA ST<br>EVANSVILLE, IN 47710 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155224 | A. BUILDING 00<br>B. WING | 10/04/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLUMBIA HEALTHCARE CENTER | 621 W COLUMBIA ST<br>EVANSVILLE, IN 47710 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0514 SS=D | 483.75(l)(1)<br>RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br>Based on interview and record review, the facility failed to ensure documentation was complete in regard to the assessment of a resident's complaints of abdominal pain, for 1 of 3 residents assessed for documentation, in a sample of 4. Resident A<br><br>Findings include:<br><br>1. On 10/4/12 at 9:10 A.M., during interview with CNA #5, she indicated she was working at the facility on 9/29 and 9/30/12. CNA # 5 indicated Resident A had complained of stomach pains, and had asked to go to the hospital on 9/29 "around midnight." CNA # 5 indicated she heard the resident complain, and assisted CNA # 4 in cleaning up the resident when he vomited. CNA # 5 | F0514 | F514 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State It is the policy of the facility that services provided **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>·Resident A no longer at the facility **How will you identify other residents having the** | 10/24/2012 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155224 | A. BUILDING 00<br>B. WING | 10/04/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLUMBIA HEALTHCARE CENTER | 621 W COLUMBIA ST<br>EVANSVILLE, IN 47710 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | indicated RN # 2 was aware of the resident's complaints.<br><br>On 10/4/12 at 1:15 P.M., during interview with CNA # 4, she indicated she was working on 9/29. CNA # 4 indicated Resident A "was bloated, hurting, and was wanting to go to the hospital." CNA # 4 indicated she informed RN # 2. CNA # 4 indicated the resident vomited "dark brown liquid."<br><br>On 10/4/12 at 9:30 A.M., during interview with RN # 2, she indicated she was working at the facility on 9/29/12. She indicated she was informed early Sunday, 9/30, "probably around 6 or 7 A.M.," that Resident A's "belly hurt." RN # 2 indicated she assessed the resident, and his abdomen was large, "but it was always large." RN # 2 indicated the resident was rubbing his lower abdomen. RN # 2 indicated she heard bowel sounds when she listened to the resident. RN # 2 indicated the resident did not vomit, and she did not feel the physician needed to be notified.<br><br>Documentation regarding the resident's complaints of abdominal pain, or the nursing assessment, was not observed in the clinical record.<br><br>2. On 10/4/12 at 2:15 P.M., the Director | | **potential to be affected by the same deficient practice and what corrective action will be taken?**<br>·All residents that reside within the facility have the potential to be affected by the alleged deficient practice.<br>· All nurses/have been in-serviced on documentation requirements and importance of documentation of assessments. DNS/SDC will inservice all licensed nursing staff by October 24, 2012.<br>·Nurse managers have received training to audit nurse documentation to ensure that documentation of assessments was completed. DNS/SDC to train nurse managers by October 24, 2012.**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>·Licensed nursing staff has been educated on assessment and documentation policy. DNS/SDC trained all licensed nursing staff by October 24,2012.<br>· Nursing staff will be instructed to assess any resident identified by any staff member to be in distress and document findings.<br>·DNS/Designee/UM will conduct | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155224 | A. BUILDING 00<br>B. WING | 10/04/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLUMBIA HEALTHCARE CENTER | 621 W COLUMBIA ST<br>EVANSVILLE, IN 47710 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | of Nursing provided the current facility policy on "Documentation guidelines for nursing," revised 6/2012. The policy included: "Purpose: To accurately document in an organized manner all information related to the resident in the medical record...Daily charting in the nursing progress notes on resident specific conditions including vital signs, pain symptoms...."<br><br>This federal tag relates to Complaint IN00117509.<br><br>3.1-50(a)(1) | | rounds daily on all shifts to validate that regular scheduled assessments are completed and assessments are done for any suspected change in condition and documentation is complete for assessments<br>·The DNS /designee will complete documentation CQI tool 5X weekly X 4 weeks, weekly X 4, and quarterly thereafter. For a minimum of 6 months All audit tools will be brought before the CQI committee monthly<br>·Any non-compliant issues may be addressed with re-education and/or disciplinary action up to and including termination.<br>**Compliance date:** October 24, 2012 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155224 | A. BUILDING 00<br>B. WING | 10/04/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLUMBIA HEALTHCARE CENTER | 621 W COLUMBIA ST<br>EVANSVILLE, IN 47710 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | | |